

Medicaid Home and Community Based Services Waivers

Generally Medicaid services must be available in the same amount, duration, and scope to everyone on Medicaid, and individuals must be able to choose their own providers. Waivers allow states to “waive” some or all of those requirements.

Home and Community Based Services (HCBS) Waivers (§ 1915 (c) of SSA)

- Can waive statewideness.
- Can waive comparability of services.
- Can waive community income and resource rules.
- Can waive rules that require States to provide services, on an equal basis, to all persons in the State.
- States have the flexibility to design each waiver and select the mix of services that best meets the needs of the population they wish to serve.
- May be provided statewide or may be limited to specific geographic subdivisions.
- Waivers can be targeted to specific groups or any subgroup thereof that the State may define: aged or disabled, or both; mentally retarded or developmentally disabled or both; and mentally ill. Cannot be targeted to people in an Institution for Mental Disease (IMD). States cannot get waivers with an alternate institutional placement of an Institution for Mental Disease (IMD). Medicaid does not pay for any services for people in IMDs who are between the ages of 21 through 64.
- Initially approved for 3 years and renewed every 5 years.
- Optional programs that afford States the flexibility to develop and implement alternatives to institutionalizing Medicaid eligible individuals.
- The program recognizes that many individuals who would otherwise be institutionalized can be cared for in their homes and communities at a cost no higher than that of institutional care when compared on an average basis. This does not mean that waivers are a cost-savings to States since many people who would not enter an institution will choose community care. The bottom line is that waivers can be costly to states.
- To receive approval to implement a waiver, a State Medicaid agency must assure the Centers for Medicare and Medicaid Services (CMS) that it will not cost more, on average, to provide home and community based services than providing institutional care would cost. Waiver recipients must be offered the choice of institutional or community placement. The average costs of individuals on the waiver are compared to the average costs of individuals in the institution.
- The State must also assure CMS that there are safeguards to protect the health and welfare of recipients.

- Waivers must be submitted by the single state Medicaid agency (DMAS). The single state agency must not delegate, to other than its own officials, authority to:
 - ☒ exercise administrative discretion in the administration or supervision of the plan, or
 - ☒ issue policies, rules, and regulations on program matters.
 - ☒ The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.
 - ☒ If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency. 42 C.F.R. 431.10.

The Commonwealth of Virginia Had Six HCBS Waivers in FY 2004:

1. AIDS Waiver
2. Consumer Directed Personal Attendant Services (CD-PAS) Waiver (In February, 2005 the CD-PAS and Elderly and Disabled Waivers were combined into the Elderly or Disabled with Consumer-Direction Waiver (EDCD))
3. Elderly and (or) Disabled (E&D) Waiver
4. Individual and Family Developmental Disabilities Support Waiver (DD Waiver).
5. Mental Retardation Waiver (MR)
6. Technology Assisted Waiver (Tech)

As of July 1, 2005, Virginia had six waivers, which included the AIDS, DD, EDCD, MR, and Tech Waivers, and a Day Support Waiver for people with Mental Retardation (300 slots), which became effective July 1, 2005. An additional waiver, the Alzheimer's Assisted Living Waiver (200 slots), was approved by CMS effective July 1, 2005, but was not yet operational since State regulations were not yet in place. This waiver is expected to be operational in the fall of 2005.

AIDS Waiver

Initiative	Purpose is to provide care in the community rather than in nursing facilities or hospitals.
Targeted Population:	Diagnosis of AIDS or AIDS Related Condition (ARC) and documentation that the individual is experiencing medical and functional symptoms associated with AIDS or ARC which would require nursing facility or hospital care
Eligibility Rules	Must be eligible for Medicaid and meet screening criteria; income limit is 300% of the SSI payment limit for one person (\$1,737/month). No patient pay.
Services Available	<ul style="list-style-type: none"> • Case management • Nutritional supplements • Private duty nursing • Personal care (consumer or agency directed) • Respite care
Service Authorization	Local and hospital screening teams
Program Administration	Program administered by DMAS
Service Provision	Services are provided by case management providers or personal care and nursing agencies that have a provider agreement with DMAS.
Number of People Served	274 people were served in FY 2004.
Cost	Waiver costs were \$608,497 in FY '04. Other costs for people on the Waiver were \$6,117,320 (\$4 million was for pharmacy)

Consumer Directed Personal Attendant Services Waiver

Initiative	Purpose is to provide care in the community rather than in a nursing facility.
Targeted Population:	Individuals 65 or older or who are disabled, who meet screening criteria and are at imminent risk of nursing facility placement. Individuals must be able to hire, train and fire, if necessary, their own attendants, or have a parent, spouse, legal guardian, or adult child who directs care on their behalf if they cannot do so.
Eligibility Rules	Must be eligible for Medicaid and meet screening criteria; income limit is 300% of the SSI payment limit for one person (\$1,737 /month). Could have a patient pay if income is in excess of SSI income limit for one (\$579). Due to expenses of employment, can keep additional amount of earned income if working more than 8 hours/ week.
Services Available	Personal attendant services
Service Authorization	Local and hospital screening teams
Program Administration	Program administered by DMAS
Service Provision	Personal attendants hired by the recipient. Service coordination is provided by registered nurses, social workers or case managers who have a provider agreement with DMAS. Service coordinators assess, develop and monitor the care plan.
Number of People Served	417 people were served in FY 2004
Cost	The cost of waiver services was \$4,403,107 in FY '04; the cost of acute care services was an additional \$2,334,535.

Elderly and (or) Disabled Waiver

Initiative	Purpose is to provide care in the community rather than in a nursing facility.
Targeted Population:	Individuals 65 or older <u>or</u> who are disabled <u>and</u> who meet screening criteria and are at imminent risk of nursing facility placement (42 CFR 441.302(c)(1).
Eligibility Rules	Must be eligible for Medicaid and meet screening criteria; income limit is 300% of the SSI payment limit for one person (\$1,737 month). Could have patient pay if income is in excess of SSI income limit for one (\$579).
Services Available	<ul style="list-style-type: none"> • Adult day health • Respite care • Personal care • Personal Emergency Response System
Service Authorization	Local and hospital screening teams
Program Administration	Program administered by DMAS
Service Provision	Services are provided by personal care and nursing agencies that have a provider agreement with DMAS.
Number of People Served	In FY 2004, 10,161 people were served.
Cost	Waiver expenditures for FY 2004 were \$101,354,887 Other costs for Waiver recipients were \$78,082,480

Individual and Family Developmental Disabilities (DD) Support Waiver Revised 8/7/2005

Initiative	Home and Community Based (1915(c)) waiver whose purpose is to provide care in the community rather than in an Intermediate Care Facility for the Mental Retarded (ICF/MR).
Targeted Population:	Individuals who are 6 years of age and older who have a related condition and do not have a diagnosis of mental retardation who (1) meet the ICF/MR level of care criteria (i.e., they meet two out of seven levels of functioning in order to qualify); (2) are determined to be at imminent risk of ICF/MR placement, and (3) are determined that community-based care services under the waiver are the critical services that enable the individual to remain at home rather than begin placed in an ICF/MR.
Eligibility Rules	<p>Individual Eligibility</p> <p>An individual is deemed eligible for DD Waiver services based on three factors:</p> <ul style="list-style-type: none">➤ <u>Diagnostic Eligibility:</u> Individuals age six and older must have a psychological or standardized developmental evaluation that states that the child does not have a diagnosis of mental retardation or is at developmental risk and reflects the child's current level of functioning.➤ <u>Functional Eligibility:</u> All individuals receiving DD Waiver services must meet the ICF-MR (Intermediate Care Facility for Mental Retardation) level of care. This is established by meeting the indicated dependency level in two or more of the categories on the "Level of Functioning Survey."➤ <u>Financial Eligibility:</u> An eligibility worker from the local Department of Social Services (DSS) determines an individual's financial eligibility for Medicaid. Some individuals who would not ordinarily qualify financially for Medicaid may be eligible by receipt of DD Waiver services. <p>Medicaid regulations specify that, once an individual has been determined eligible by the IFDDS screening team, he or she must be offered a choice between institutional and Waiver services.</p>
Services Available	<ul style="list-style-type: none">• Case management: is the assessment, planning, linking and monitoring for individuals referred for the DD Waiver. It also ensures the development, coordination, implementation, monitoring, and modification of consumer service plans; links individuals with appropriate community resources and supports;

coordinates service providers; and monitors quality care.

- **In– Home Residential Support Services:** training, assistance and specialized supervision, provided primarily in an individual’s home to help the person learn or maintain skills in activities of daily living, safety in the use of community resources, and behavior appropriate for home and the community.
 - **Day support:** training, assistance and specialized supervision to enable the individual to acquire, retain or improve his/her self-help, social and adaptive skills. These services typically take place away from the home in which the individual resides and may be located in a “center” or in community locations.
 - **Supported employment:** supports to enable individuals with disabilities to work in settings in which persons without disabilities are typically employed. It may be provided to one person in one job (e.g., a person working to bus tables in a restaurant) or to several people at a time when those individuals are working together as a team to complete a job (e.g., such as a grounds maintenance crew).
 - **Prevocational services:** training and assistance to prepare an individual for paid or unpaid employment. These services are not job task-oriented. These are for individuals who need to learn skills fundamental to employment such as accepting supervision, getting along with co-workers, using a time clock, etc.
- • **Personal assistance:** direct support with activities of daily living (e.g., bathing, toileting, personal hygiene skills, dressing, transferring, etc.), instrumental activities of daily living (e.g.,
- assistance with housekeeping activities, preparation of meals, etc.), accessing the community, taking medication or other medical needs, and monitoring the individual’s health status and physical condition. These services may be agency-directed or *consumer-directed*.
- **Respite:** services designed to provide temporary, substitute care for that which is normally provided by the family or other unpaid, primary caregiver of an individual. These short-term services may be provided because of the primary caregiver’s absence in an emergency or on-going need for relief. These services may be agency-directed or *consumer-directed*.
- **Companion:** provide non-medical care, socialization or support to adults in an individual’s home or at various locations in the community. These services may be agency-directed or *consumer-directed*.

- **Consumer-directed services:** offer the individual/family the option of hiring workers directly, rather than using traditional agency staff.
- **Assistive technology:** specialized medical equipment, supplies, devices, controls and appliances, which enable the individual to better perform activities of daily living, to perceive, control or communicate with his/her environment, or which are necessary to his/her proper functioning.
- **Environmental modifications:** physical adaptations to an individual's home or vehicle needed by the individual to ensure his/her health, welfare and safety or enable him/her to experience greater independence in the home and around the community.
- **Skilled nursing services:** nursing services ordered by a physician for individuals with serious medical conditions and complex health care needs. This service is available only for individuals for whom these services cannot be accessed through another means. These services may be provided in an individual's home, community setting, or both.
- **Therapeutic consultation:** expert training and technical assistance in any of the following specialty areas to enable family members, caregivers, and other service providers to better support the individual. The specialty areas are: Psychology, Social Work, Speech and Language Pathology, Occupational Therapy, Physical Therapy, Therapeutic Recreation, Psychiatric Clinical Nursing, and Rehabilitation.
- **Crisis stabilization:** direct intervention (and may include one-to-one supervision) to a person with developmental disabilities who is experiencing serious psychiatric or behavioral problems which jeopardize his/her current community living situation.
- **Personal emergency response systems (PERS):** an electronic device that enables the individual who is alone to access a centralized, staffed emergency center in the event of an emergency.
- **Family and Caregiver:** training will provide training and counseling services to families of individuals receiving services in the DD Waiver

	form screening team . The screening request is taken to one of the 11 Child Development Clinics designated to serve as the screening team for the DD Waiver. If the screening team determines the individual meets criteria, a service plan is created and DMAS assigns a slot to the individual once a slot becomes available.
Program Administration	The program is administered by the Department of Medical Assistance Services (DMAS). DMAS also conducts preauthorization of DD Waiver services.
Number of People Served	FY2004 392

Waiting List

A waiting list does exist for the DD Waiver. The waiting list is maintained on a first-come, first served basis. Individuals are assigned waiting list numbers based on the date DMAS receives the Screening Packet from the screening.

If an individual is determined eligible, a case manager works with the individual to develop a Plan of Care (POC). The amount of the POC determines which level waiting list the individual is assigned. Individuals whose care plans are below \$25,000 are assigned to Level I. Individuals whose care plans exceed \$25,000 are assigned to Level II.

Emergency Criteria

Subject to available funding, individuals must meet at least one of the emergency criteria to be eligible for immediate access to waiver services without consideration to the length of time an individual has been waiting to access services. In the absence of waiver services, the individual would not be able to remain in his home.

A. The criteria are:

1. The primary caregiver has a serious illness, has been hospitalized, or has died; or
2. The individual has been determined by the DSS to have been abused or neglected and is in need of immediate Waiver services; or
3. The individual has behaviors which present risk to personal or public safety; or
4. The child presents extreme physical, emotional or financial burden at home and the family or caregiver is unable to continue to provide care.

Providers:

An institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by DMAS, and has a current, signed contract with DMAS to be a provider of DD Waiver services.

Accessing DD Waiver Services

- Individual, family or representative requests services from the Case Manager.
- The case manager determines the preferred services and necessary supports by meeting with the individual and family (or other caregivers) and confirms diagnostic and functional eligibility by obtaining a psychological evaluation and completing an ICF/MR Level of Functioning Survey (LOF).
- Once the individual is determined eligible (including financial eligibility through the Department of Social Services), the case manager informs the individual and family of the full array of DD Waiver services and documents the individual's choice of Waiver or institutional care.
- Once it is determined that a slot is available and the individual has been enrolled, the individual selects providers for needed services. The case manager coordinates the development of a Consumer Service Plan (CSP) with the individual, family or other caregivers and the service providers within 60 days of enrollment. The CSP includes all of the supporting documentation developed by this team and describes the services that will be rendered.
- Prior to the start of services, the case manager forwards appropriate documentation to DMAS staff for review and authorization of the requested DD Waiver services.
- Once approved, DMAS staff enters service data in the DMAS computer system. This generates a notification letter to the providers and permits them to bill for approved services. Service provision should commence within 60 days from enrollment.

For additional information, please contact Ms. Pat Arevalo, Supervisor, Behavioral Health and Developmental Disabilities Unit of DMAS, at (804) 786-1465 or by e-mail at Pat.arevalo@dmass.virginia.gov.

Mental Retardation Waiver

Initiative	Purpose is to provide care in the community rather than in an Intermediate Care Facility for the Mentally Retarded.
Targeted Population	Individuals with mental retardation or related conditions and individuals under the age of 6 at developmental risk who have been determined to require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).
Eligibility Rules	Must be eligible for Medicaid and meet screening criteria; income limit is 300% of the SSI payment limit for one person (\$1,737/month). Could have a patient pay if income is in excess of SSI income limit for one (\$579). Could have a patient pay if income is in excess of SSI income limit for one (\$579). Due to expenses of employment, can keep additional amount of earned income if working more than 8 hours/ week.
Services Available	<ul style="list-style-type: none"> • Day support • Supported employment • Residential supports (Congregate and In-Home) • Therapeutic consultation • Personal assistance services (consumer or agency directed) • Respite care (consumer or agency directed) • Skilled nursing services • Crisis Stabilization • Environmental Modifications • Assistive Technology • Companion (consumer or agency directed)
Service Authorization	Community Mental Health Services Boards (CSB)
Program Administration	Program administered by DMAS and DMHMRSAS
Service Provision	Services are provided by providers who have an agreement with DMAS.
Number of People Served	5,622 people were served during FY 2004. There is a waiting list for services.
Cost	Waiver costs were \$227,229,982 in FY '04. Other costs for people on the waiver were \$78,821,941.

Technology Assisted Waiver

Initiative	Purpose is to provide care in the community rather than in a nursing facility (adults) or hospital (children).
Targeted Population:	Individuals who need both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care.
Eligibility Rules	Must be eligible for Medicaid and meet screening criteria; income limit is 300% of the SSI payment limit for one person (\$1,737/month). Could have a patient pay if income is in excess of SSI income limit for one (\$579).
Services Available	<ul style="list-style-type: none"> • Private duty nursing • Respite care • Durable medical equipment • Personal care • Environmental modification
Service Authorization	Health Care Coordinator who is either an employee of DMAS or a DMAS contractor
Program Administration	Program administered by DMAS
Service Provision	Case management is provided by DMAS staff. Nursing services are provided by nursing agencies that have a provider agreement with DMAS.
Number of People Served	339 served in FY 2004
Cost	The cost of waiver services was \$19,648,061 in FY '04; the cost of acute care services was an additional \$7,109,713.